State of Michigan

Flexible Spending Account
2007 Plan Booklet

Employee Benefits Resource Directory

Company	Department	Hours	Phone/Web Address
Automatic Data Processing (ADP) (Flexible Spending Accounts)	Solution Center	8 a.m.—8 p.m. EST Monday—Friday	Phone: (Toll Free) 800-422-3703 TDD: (Toll Free) 800-284-7904
ADP Claims Processing P O Box 1853 Alpharetta, GA 30023-1853			Fax: (Toll Free) 866-392-4090 or 678-762-5900
On-Line Account Information			Effective January 1, 2007: https://www.flexdirect.adp.com/mifsa/
Health Care Debit Card	Lost or Stolen Card	24 Hours a Day	Phone: (Toll Free) 800-422-3703

Company	Department	Hours	Phone/Web Address
State of Michigan	MI HR Service Center P O Box 30002 Lansing, MI 48909	7 a.m.—6 p.m. EST Monday—Friday	Phone: (Toll Free) 877-766-6447 Local: 517-335-0529 TDD: 517-241-8046 Fax: 517-241-5892 www.michigan.gov/selfserv
	Department of Civil Service Employee Benefits Division 400 South Pine Street P O Box 30002 Lansing, MI 48909	8 a.m.—5 p.m. EST Monday—Friday	1-800-505-5011 www.michigan.gov/mdcs Click on 'Employee Benefits', then 'Flexible Spending'

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Introduction to the Flexible Spending Account Plan

The State of Michigan is pleased to sponsor an employee benefit program known as The Flexible Spending Account Plan. There are two types of flexible spending accounts: a Health Care Spending Account (HCSA) and a Dependent Care Spending Account (DCSA).

The Plan is called a "flexible" spending account because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year. You elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) *on a pre-tax basis* for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the HCSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the DCSA. It is important that you carefully determine the amount you want to allocate to the Plan because any amounts that are not used for expenses incurred during the plan year and corresponding grace period will be forfeited.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses are withheld *before* any federal income and employment taxes (e.g., FICA) are applied and before any applicable Michigan state taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take-home pay over what your net take-home pay would be if you paid for such expenses with after-tax dollars.

This Plan Booklet is divided into three parts:

- Part I: General Information about the Plan;
- Part II: HCSA Benefits; and
- Part III: DCSA Benefits.

This Plan Booklet is in a question and answer format. We encourage you to read the entire booklet, but if you have questions about your rights and obligations under the Plan, please refer to the Table of Contents for the question that most closely resembles your question.

This Plan Booklet describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it.

Part I: General Information about Flexible Spending Accounts (FSAs)
Questions and Answers

1. What is the purpose of a Flexible Spending Account (FSA)?

The purpose of an FSA is to allow eligible employees to use pre-tax dollars to pay for eligible, unreimbursed medical and/or dependent day care expenses.

2. Who can participate in the FSAs?

All State of Michigan employees except non-career, and Special Personal Services (SPS) employees can participate in Flexible Spending Accounts. Employees who are hired as seasonal employees must ensure the number of deduction pay dates elected is within the months of employment to ensure the annual deduction amount can be fulfilled.

3. How do I become a participant?

- Carefully read this booklet and calculate your estimated expenses.
- During the enrollment period, you may call the ADP Participant Solution Center toll free at 1-800-422-3703, to determine what expenses are eligible. The ADP Participant Solution Center cannot assist with enrollment or with MI HR Self-Service questions.
- You can use the online calculators on the State of Michigan Web site at www.michigan.gov/mdcs. Click 'Employee Benefits', then 'Flexible Spending, then 'Calculators' to calculate your estimated tax savings.
- Enrollments must be entered using MI HR Self-Service at www.michigan.gov/selfserv.
- Access to MI HR Self-Service is available 7 days a week (via the Internet/Intranet), except during regularly scheduled maintenance. The maintenance schedule and password assistance are available on the MI HR Gateway at www.michigan.gov/selfserv.
- When you have completed your online enrollment, you will immediately receive an electronic Confirmation Statement on the screen that you must print and retain.
- Please contact the MI HR Service Center at 1-877-766-6447 or at 1-517-335-0529 if you do not have access to a computer or need assistance with MI HR Self-Service.
- **Your enrollment must be completed between November 1, 2006 and November 28, 2006.**

4. What are the enrollment periods under the Plan?

New Employees: If you wish to enroll in the Flexible Spending Accounts you must contact the MI HR Service Center within 30 days of your hire date. If you do not enroll during this initial eligibility period, you must wait until the next annual Open Enrollment or until you experience a valid Life Event Change.

After completion of the benefits enrollment, coverage will be effective on the first day of the bi-weekly payroll period following either:

- Your first day of employment, or
- The date when the enrollment process is completed, whichever is later.

If you enroll during Open Enrollment, your period of coverage is the same as the plan year (January 1, 2007 through December 31, 2007).

Current Employees: You must enroll during the annual Open Enrollment. The 2007 Plan Year open enrollment dates are November 1, 2006 through November 28, 2006, unless you have an eligible Life Event Change as described in question 9.

If you are a current participant in the Flexible Spending Accounts and you fail to enroll during the Annual Enrollment Period, you will be deemed to have elected not to participate during the 2007 Plan Year.

5. How are the contributions to the spending accounts made under the Plan?

When you become a participant in the Plan, your contributions for the elected spending accounts will be paid with pre-tax contributions that you elected when you enrolled. Pre-tax contributions are amounts withheld from your gross income before any applicable federal taxes and Michigan state taxes have been applied.

6. What is my period of coverage?

Current Employees: Your period of coverage for incurring expenses is the full 2007 plan year January 1, 2007 through December 31, 2007, plus the corresponding grace period of January 1, 2008, through March 15, 2008.

New Employees: After completion of the benefits enrollment, coverage will be effective on the first day of the bi-weekly payroll period following either:

- Your first day of employment, or
- The date when the enrollment process is completed, whichever is later.

If you enroll during Open Enrollment, your period of coverage is the same as the plan year (January 1, 2007, through December 31, 2007), plus the corresponding grace period of January 1, 2008, through March 15, 2008.

7. What is a split period of coverage?

For a Health Care FSA, a mid-plan year election change due to a Qualifying Life Event will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change, however, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Health Care FSA prior to the change.

Split periods of coverage do not apply to Dependent Care FSAs.

8. What are the IRS Special Consistency Rules Governing Life Event Changes?

- *Loss of Dependent Eligibility* – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
- *Gain of Coverage Eligibility Under Another Employer's Plan* – If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
- *Dependent Care Expenses* – You may change or terminate your Dependent Care FSA election when a Life Event Change affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

9. Can I ever change my election during the Plan Year?

You cannot change your election to participate in the Plan or vary the pre-tax contribution that you have elected to allocate to the HCSA and/or the DCSA unless you have a Qualifying Life Event. Your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your pre-tax contribution elections during the annual enrollment period, and then, only for the coming plan year.

There is an important exception to this general rule. You may change or revoke your elections or join the plan during the Plan Year within 30 days of experiencing one of the following events. Note that not all of the events apply to HCSA elections.

A. **Life Event Change**. If one or more of the following "Life Event Changes" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and consistent with a Life Event Change (as described below), as well as any other events permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse).
- A change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent).
- Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under this Plan or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a commencement of or return from an unpaid leave of absence, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit.
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student).

The election change must be based solely on and correspond with the Life Event Change. With the exception of an election change to the HCSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Life Event Change if the event affects eligibility for coverage under the Plan. A Life Event Change affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Life Event Change:

Gain of Coverage Eligibility Under Another Employer's Plan. For a Life Event Change in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Life Event Change *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

Dependent Care Reimbursement Plan Benefits. With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) such change or termination is made solely on the basis of and directly corresponding with a Life Event Change that affects eligibility for coverage under the Plan; *or* (2) your election change is based solely on and corresponds with a Life Event Change that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Life Event Change. Mike's election to cancel coverage under the dependent care program would be consistent with this Life Event Change.

B. **Special Enrollment Rights** (NOTE: This applies to HCSA elections only). If you declined enrollment in

medical coverage for yourself or your eligible dependents because of outside medical coverage and coverage is lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect HCSA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30 day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

C. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

D. **Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may modify or cancel HCSA coverage correspondingly. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility, you may elect to begin or increase that person's HCSA coverage.

E. **Change in Cost** (applies only to DCSA elections). If you are notified that your dependent care cost has *significantly* increased or decreased or will *significantly* increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. The Plan Administrator for the State of Michigan will have final authority to determine whether the requirements of this section are met.

F. **Change in Coverage** (applies only to DCSA elections). If your need for coverage under the DCSA is significantly reduced, you may revoke your election and either choose another day care provider or drop coverage altogether. In addition, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is solely based upon and corresponding with a change made under another employer plan (including a plan of the Employer or another employer), provided: (i) the other employer plan allows its participants to make an election change permitted under the IRS regulations; or (ii) the Plan Year for this Plan is different from the Plan Year of the other employer plan.

G. **Approved Leave of Absence**. If you are granted an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

- If you go on a qualifying unpaid leave under the Family and Medical Leave Act (FMLA) of 1993, you have the option to continue your HCSA. If you opt to continue your HCSA while you are on leave, you may:
    a. Pay your share of the contribution with after-tax dollars while on leave, or
    b. You may choose to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with pre-tax contributions from your pre-leave compensation. The contribution may be paid not to exceed the end of the Plan Year. In this case, you would make a special election to your account before the date such compensation adjust-

ments would be made to your pre-leave paychecks, or by other arrangements agreed upon by you and the Employee Benefits Division.

- If your HCSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the HCSA upon return from your leave on the same basis as you were participating in the HCSA prior to the leave, or as otherwise required by the FMLA.
- The Employer may continue your HCSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution.
- If you are beginning or returning from an unpaid FMLA leave, you will be permitted to re-enter the DCSA upon your return from leave on the same basis as prior to the leave.

10. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

11. What is the timeframe for making changes to my accounts based on Qualifying Life Event Changes?

You can change your Flexible Spending Account (FSA) election(s) or vary the salary reduction amounts you have selected during the plan year only under limited circumstances as specified in IRS guidelines. Partial lists of permitted qualifying events under your employer's plan(s) appear on the previous pages. *Election changes must be consistent with the event.*

Within **30 days** of an event that is consistent with one of the events on the previous pages, you may stop or modify your flexible spending account by contacting the Employee Benefits Division. You will be required to provide appropriate documentation substantiating the Life Event.

Mid-year plan election changes can only be made prospectively and will be effective the first payroll after your election change request has been processed. If your FSA election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with the Employee Benefits Division.

Flexible Spending Account Plan
Part II: Health Care Spending Account (HCSA) Benefits

The following Questions and Answers relate to the HCSA benefits.

12. What is the "Health Care Spending Account (HCSA)"?

The Health Care Spending Account (HCSA) is the portion of the Plan that provides for reimbursement of Eligible Medical Expenses incurred by the Participant and his/her Eligible Dependents. A Health Care Spending Account can save you money on eligible out-of-pocket health care expenses, such as doctor office co-pays, dental and medically needed orthodontia co-pays, prescription co-pays, health insurance deductibles, vision expenses not covered by insurance, and some over-the-counter drugs such as cold and allergy medications, pain relievers and antacids.

13. What is the maximum and minimum annual reimbursement amount that I may elect under the HCSA?

You may choose any reimbursement amount you desire subject to the minimum and maximum annual HCSA Reimbursement Amount listed below.

Minimum Annual Deposit: $2 bi-weekly
Maximum Annual Deposit: $5,000 annually

14. How are amounts allocated to the HCSA withheld from my pay?

When you enroll, you specify the amount of bi-weekly pre-tax contribution and also indicate the number of pay periods (1-26) that you wish the contribution to be deducted from your pay.

15. What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

16. How do I receive reimbursement under the HCSA?

When you incur an Eligible Medical Expense, you may file a claim with ADP by completing and submitting a Request for Reimbursement form. You can obtain a Request for Reimbursement form from ADP or by downloading the form online at www.michigan.gov/mdcs. Click 'Employee Benefits' from the left menu, then select 'Flexible Spending'. You must include a statement from the service provider (e.g., a receipt, EOB, etc) associated with each expense that indicates the following:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug.
- The date the expense was incurred.
- The amount of the expense.

You may be required to provide additional substantiation to support your claim. ADP will process the claim once it receives the Request for Reimbursement form from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made within 5 business days after receiving and processing the claim. If the expense is determined not to be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses by April 15, 2008.

You may also use an ADP Health Care Debit Card to pay expenses at the time they are incurred. The terms of the electronic payment card are located on pages 21 to 22 in this booklet.

17. What is an "Eligible Medical Expense?"

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d).
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse (in accordance with federal law) and any other individual who is a "dependent" as defined in Code Section 105(b). Coverage for an individual covered as an Eligible Dependent under the HCSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Also, "stockpiling" of over the counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year.
In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any HCSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services

18. When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while a participant and/or during the grace period immediately following the Plan year. An expense is incurred when the service or treatment has been performed and not in advance of the service. You may not be reimbursed for any expenses arising before the HCSA becomes effective, before your HCSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

You can also use money in your 2007 account that is unused after December 31, 2007, for expenses incurred during the grace period, January 1, 2008 through March 15, 2008.

19. What if the Eligible Medical Expenses I incur during the Plan Year and corresponding Grace Period are less than the annual amount I have contributed to the HCSA?

You will not be entitled to receive any payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and the annual reimbursement amount that you have elected. Any money remaining in your HCSA will be forfeited if it has not been applied to reimburse expenses incurred during the Plan Year, and the Grace Period, January 1, 2008 through March 15, 2008. The Run-out Period is from January 1, 2008

through April 15, 2008.

20. What happens if a Claim for Benefits under the HCSA is denied?

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from ADP:* If your claim is denied, you will receive written notice from ADP that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, ADP may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which ADP must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully:* Once you have received your notice from ADP, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary to process your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision:* If you do not agree with the decision of ADP, you may file a written appeal with ADP no later than 180 days after receipt of the notice.

- You should submit all information identified in the notice of denial as necessary to process your claim and any additional information that you believe would support your claim.
- Notice of Denial is received from claims reviewer. If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by ADP.
- Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by ADP.

Step 4: *If you still disagree with ADP's decision:* If you still do not agree with ADP's decision, you may file a written appeal with the State of Michigan within 30 days after receiving the first level appeal denial notice from ADP. You should gather any additional information that is identified in the notice that is necessary to process your claim, and submit other information that you believe would support your claim.

You may send your 2nd level appeal to:

Department of Civil Service
Employee Benefits Division
400 S Pine Street
P O Box 30002
Lansing, MI 48909

If the State of Michigan denies your 2nd level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

21. What happens to unclaimed HCSA reimbursements?

Any reimbursements under the HCSA that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year

following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

22. What is continuation coverage?

Federal law requires that the State of Michigan Health Care Flexible Spending Accounts (HCSA) give employees and their families the opportunity to continue their coverage when there is a "qualifying event" that would result in a loss of coverage. "Qualified beneficiaries" can include the employee covered under the plan, a covered employee's spouse, and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights.

23. What happens to my Health Care FSA if I retire, go on a leave of absence, experience a layoff, experience lost time, or separate from state service?

If you are planning for any of these events to occur during the calendar year, you may sign up for your annual deduction to be spread over available pay periods. If any of these unplanned events occur during the calendar year, you must contact the MI HR Service Center at least **two weeks** prior to your last day of work or as soon as possible if the event was unpredictable. You are eligible for reimbursement of expenses that you incur after the date of your last paycheck only by continuing to make the biweekly deduction payments.

There are two options for payment of your deduction amount:

- You can arrange to have the balance of your deductions taken from your last paycheck by contacting the Employee Benefits Division. The deduction will be taken from pre-tax dollars, or
- You can arrange to pay the balance of the deductions with post-tax dollars by contacting the Employee Benefits Division.

If you do not notify the Employee Benefits Division before going off payroll, your future claims may not be reimbursed. ADP will not process claims for reimbursement of expenses incurred after the date of your last paycheck until payment has been received from you. This is true even if you had a balance in your account as of the date of your last paycheck. Paying the balance of the billed deductions will enable you to receive full reimbursement for expenses incurred through the end of the year, and recapture amounts remaining in your account at the time you went off payroll. If you return from a leave of absence, you must contact the Employee Benefits Division to discuss recovery of missed deductions and eligibility requirements.

24. How long will continuation coverage last?

For Health Care FSAs:
You may continue your Health Care FSA (post-tax) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already used your full Health Care FSA enrollment amount. For example, if you elected a maximum Health Care FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year.

25. How much does continuation coverage cost?

The cost for continuation of coverage is a monthly amount calculated and based on the amount you are paying via pre-tax salary deductions before a qualifying event.

26. When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

You must make your first payment for continuation coverage within 45 days after the date of your election. If you do not make your first payment for continuation coverage within that 45 day period, you will lose all continuation coverage rights under the Plan.
Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You may contact the MI HR Service Center to confirm the correct amount of your first payment and to obtain instructions for sending your first payment for continuation coverage.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **fifteenth day of the prior month.**

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment.
Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

For More Information
For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPPA) and other laws affecting group health plans, please contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

Flexible Spending Account Plan
Part III: Dependent Care Spending Account (DCSA) Benefits

The following Questions and Answers relate to the DCSA benefits.

27. What is the "Dependent Care Spending Account (DCSA)?"

The DCSA is the portion of the Plan that provides for reimbursement of Eligible Day Care Expenses incurred by the Participant. A DCSA can be used to pay for childcare expenses while you and your spouse are at work, looking for work, or are at school; for local day camp; and for care expenses for any incapacitated person you are eligible to claim on your income taxes.

28. What is the maximum and minimum reimbursement amounts that I may elect under the DCSA?

Maximum

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

Minimum

The minimum annual deposit is $2 bi-weekly.

29. How are amounts allocated to the DCSA withheld from my pay?

When you enroll, you specify the dollar amount of your bi-weekly pre-tax contribution and the number of pay periods (1-26) from which contributions will be deducted from your pay.

30. When can I receive reimbursement for eligible Day Care Expenses?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Health Care FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

31. How do I receive reimbursement under the DCSA?

When you incur an Eligible Day Care Expense, file a claim with ADP by completing and submitting a Request for Reimbursement form. You may obtain a Request for Reimbursement form from ADP or by downloading the form online at www.michigan.gov/mdcs. Click 'Employee Benefits' from the left menu, then select 'Flexible Spending'. You must include with your Request for Reimbursement Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The nature of the expense.
- The date or dates the services were provided.
- The amount of the expense.

ADP will process the claim once it receives the Request for Reimbursement form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made within 5 business days after receiving the

claim and processing it. If the expense is determined not to be an "Eligible Day Care Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-out Period, April 15, 2008.

32. What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the beginning of the plan year for Dependent Care Reimbursement benefits and during the calendar year and Grace Period to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

   - An individual age 12 or under who (a) lives with you; (b) does not provide over half of his/her own support; and (c) is your "child" (son, daughter, grandchild, step child, brother, sister, niece and nephew), or
   - A Spouse (as defined for purposes of federal law) or other tax dependent (as defined in Code Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year.

   Note: There is a special rule for children of divorced parents. If you are divorced, the child is only a Qualifying Individual of the "custodial" parent (as defined in Code Section 152(e)).

3. The expense is incurred for the care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a "Qualifying Individual" who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expense is not paid or payable to a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

33. When must Dependent Care FSA expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred ***during*** the Plan Year and/or during the corresponding Grace Period in which you are a participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCSA becomes effective, before your DCSA election becomes effective, or after a separation from service.

34. What if the Eligible Day Care Expenses I incur during the Plan Year are less than the annual amount I have allocated to the DCSA?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Any amount allocated to the DCSA shall be forfeited by the Participant if it has not been applied by the end of the Run Out period to reimburse expenses incurred during the Plan Year and corresponding Grace Period. The Run-out Period is from January 1, 2008 through April 15, 2008. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable rules and regulations.

35. What happens if a Claim for Benefits under the DCSA is denied?

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from ADP:* If your claim is denied, you will receive written notice from ADP as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, ADP may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully:* Once you have received your notice from ADP, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions upon which the denial is based;
- a description of any additional information necessary to process your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision:* If you do not agree with the decision of ADP, you may file a written appeal with ADP no later than 180 days after receipt of the notice described in Step 1.

- You should submit all information identified in the notice of denial as necessary to process your claim and any additional information that you believe would support your claim.
- Notice of Denial is received from claims reviewer. If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by ADP.
- Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by ADP.

Step 4: *If you still disagree with ADP's decision:* If you still do not agree with ADP's decision, you may file a written appeal with the State of Michigan within 30 days after receiving the first level appeal denial notice from ADP. You should gather any additional information that is identified in the notice necessary to process your claim, and any other information that you believe would support your claim. You may send your 2nd level appeal to:

Department of Civil Service
Employee Benefits Division
400 S Pine Street
P O Box 30002
Lansing, MI 48909

If the State of Michigan denies your 2nd level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

36. What happens to unclaimed DCSA reimbursements?

Any DCSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

37. Will I be taxed on the DCSA reimbursement I receive?

You will not normally be taxed on your DCSA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this DCSA and/or another employer's DCSA) does not exceed the statutory limits set forth on page 16. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

38. If I participate in the DCSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this DCSA, although the balance of your Eligible Day Care Expenses not reimbursed under this DCSA may be eligible for the dependent care credit.

GRACE PERIOD

The State of Michigan has established a "grace period" that follows the Plan Year ending December 31, 2007. The grace period permits you to be reimbursed for Eligible Medical Expenses and/or Dependent Care Expenses incurred during the 2007 Plan Year, as well as those incurred during the grace period. The grace period will begin on January 1, 2008, and end on March 15, 2008.

In order to take advantage of the grace period, you must be:

- a Participant in the HCSA and/or the DCSA on the last day of the Plan Year to which the grace period relates, or
- a Qualified Beneficiary who is receiving COBRA coverage under the HCSA on the last day of the Plan Year to which the grace period relates.

IMPORTANT: Any unused amounts in your Plan that are not used to reimburse eligible expenses incurred in the Plan Year and/or in the corresponding grace period will be forfeited if they are not submitted for reimbursement before the end of Run-out Period, **April 15, 2008**.

ADP HEALTH CARE DEBIT CARD

The State of Michigan permits participants to use the ADP Health Care Debit Card to pay for Eligible Expenses at the point of service. The following rules apply:

ADP Health Care Debit (Card) Terms of Usage

You may use the card to pay for HCSA expenses.

You have two reimbursement options for the HCSA. You can complete and submit a written claim for reimbursement ("Traditional Paper Claims") as indicated on page 11. Alternatively, you may use the Card to pay the expense. The following is a summary of how the Health Care Debit Card works.

ADP Health Care Debit Card: The Card allows you to pay for Eligible Expenses at the time that you incur the expense. Here is how the Card works.

a. *You must make an election to use the card.* In order to be eligible for the Card, you must agree to abide by the terms and conditions of the Plan as set forth herein and in the Cardholder Agreement including limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Plan both during the Initial Election Period and during each Annual Enrollment Period. A Cardholder Agreement will be provided to you with your Card. The card will be turned off effective the first day of each Plan Year if you do not enroll during the preceding Annual Enrollment Period. When you activate your card, the Cardholder Agreement becomes a part of the terms and conditions of your Plan.

b. *The card will be turned off when employment or coverage terminates.* The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

c. *You must certify proper use of the card.* As specified in the Cardholder Agreement, you certify during the applicable Enrollment Period that the amounts in your reimbursement account will only be used for eligible expenses and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

d. *Reimbursement under the card is limited to certain specific providers (including pharmacies).* Use of the card for HCSA reimbursement is limited to merchants who are health care providers (doctors, pharmacies, etc.) Your card will not be accepted within any general merchandise stores, such as Meijer, Target, and Kroger, even if you are purchasing prescriptions.

e. *You swipe the card at the provider like you do any other credit or debit card.* When you incur an eligible expense, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount at that time you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment is being made is an Eligible Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

f. *You must obtain and retain documentation of the expense from your medical provider each time you swipe the card.* You must obtain documentation from the provider (e.g., receipt, invoice, etc.) each time you swipe the card that includes the following information:
   - The nature of the expense (e.g., what type of service or treatment was provided). If the expense is

for an over the counter drug, the written statement must indicate the name of the drug.
- The date(s) the expense was incurred.
- The amount of the expense.

You must retain this documentation for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the card arrangement, written documentation is required to be submitted (except as otherwise provided in the Cardholder Agreement). You will receive a letter from ADP that documentation is needed. You must provide documentation to ADP within the timeframe indicated on the request. Please do not submit this documentation to ADP unless you are notified by ADP to do so.

g. *There are situations under the HCSA where documentation will not be required to be provided to ADP.* There may be situations in which you will not be required to provide the written statement to ADP. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

Co-Pay Match: As specified in the Cardholder Agreement, if the ADP Health Care Debit Card payment matches a specific co-payment you have under the component medical plan, for the particular service that was provided, you may not be required to submit substantiating documentation. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you may not be required to provide the third party statement to ADP.

Previously Approved Claim Match: As specified in the Cardholder Agreement, no documentation may be required if the expense is the same as the amount, duration and provider as a previously approved expense (e.g. ADP approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to ADP if the expense incurred is the same amount).

Provider Match Program: As specified in the Cardholder Agreement, no documentation may be required to be submitted to ADP if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of your expense and verifies the amount.

Note: You should still obtain and keep for one year the substantiating documentation from your medical provider or pharmacy when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event ADP does request it.

h. *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by ADP, you must repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan is set forth in the Cardholder Agreement. If you do not repay the Plan within the applicable time period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future Eligible Expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement and in Michigan Department of Civil Service Regulation 5.20) or the remaining unpaid amount may be treated by the Employer as any other bad debt, which will result in additional gross income for you reflected in a W-2C.

i. *You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the Electronic Payment Card, you may also submit claims under the Traditional Paper Claims approach. Claims for which the ADP Health Care Debit Card has been used cannot be submitted as Traditional Paper Claims.